



Health Insurance Exchanges: Health Insurance “Navigators” and In-Person Assistance

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Summary

The 2010 Patient Protection and Affordable Care Act (ACA, P.L. 111-148) allows certain individuals and small businesses to buy health insurance through state exchanges, beginning on October 1, 2013. The exchanges are not themselves insurers, but rather are special marketplaces where insurance firms may sell health policies that meet set, federal guidelines. As of September 2013, 16 states and the District of Columbia had secured Department of Health and Human Services (HHS) approval to create their own exchanges, 7 to enter into partnership exchanges, 26 to have federally facilitated exchanges, and 1 to have a state-based Small Business Health Options Program (SHOP)/federally facilitated individual exchange. An estimated 24 million individuals are expected to secure coverage through the exchanges by 2022.

The ACA requires exchanges to perform outreach to help consumers and small businesses make informed decisions about their insurance options, including the creation of “navigator” programs. Navigators are to carry out public education activities; provide information to prospective enrollees about insurance options and federal assistance; and examine enrollees’ eligibility for other federal or state health care programs, such as Medicaid. Navigators may assist consumers in comparing insurance plans, but may not determine their eligibility for subsidies or enroll them in plans—functions that are left to the exchanges. A variety of organizations may become navigators, including labor unions, trade associations, chambers of commerce, and other entities. Navigators may not be health insurers or take compensation from insurers for selling health policies. Navigators will be required to have 20-30 hours of training on consumer privacy, exchanged-based insurance offerings, and other issues. HHS in August 2013 allocated \$67 million in 12-month grants for navigators at federally facilitated and partnership exchanges. In addition, HHS has determined that state-based exchanges may use ACA exchange establishment funds to create parallel, in-person, or non-navigator, assistance programs that perform the same function as navigators. Exchanges must also certify “certified application counselors” to help with outreach and enrollment, though no new ACA funds are available for such programs.

Consumers and small businesses may continue to use insurance brokers and agents, including web-based brokers, to compare and buy coverage, both on and off the exchanges. Brokers and agents are licensed by the states, and are generally paid on a commission basis by insurance companies. While brokers and agents may choose to become navigators, they may not accept compensation from health insurance companies in that role. Consumers may also purchase policies directly from health insurers. Outside non-profit groups and businesses, such as insurers, are launching their own separate efforts to educate consumers about the ACA and the process of applying for qualified health plans (QHP) and other programs.

Some lawmakers, agents, and brokers have raised questions about the navigator and other assistance programs. Issues include whether navigators will have sufficient training and whether HHS regulations provide sufficiently stringent consumer and privacy safeguards. A number of states have passed legislation to further regulate navigators, including requiring navigators to be licensed and to be liable for financial losses due to their advice. HHS has determined that the ACA gives states authority to set additional standards, so long as they do not prevent implementation of Title I of the law, which includes the exchanges and navigator program. This report describes exchange outreach programs, the role of brokers, agents and insurers, and emerging issues regarding consumer outreach assistance.

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Introduction

The 2010 Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) mandates the creation of state health care exchanges for the sale of insurance policies, including certain individual and small-group policies.¹ Under the ACA, a state may set up its own exchange or create an exchange in partnership with the federal government. If a state chooses not to form an exchange, or cannot meet ACA requirements, the Department of Health and Human Services (HHS) will run its exchange. (See text box below, “Glossary of ACA Terms.”)

Glossary of ACA Terms

State-Based Exchange—As exchange set up and run by a state, following ACA guidelines. Can be designed as a non-profit or governmental entity. Under a state-based exchange, HHS may carry out some functions, such as reinsurance, risk adjustment, and determining eligibility for premium subsidies, and tax credits.

Federally Facilitated Exchange—If a state chooses not to operate its own exchange, or does not have approval to operate its own exchange, the Secretary of HHS is required to establish a federally facilitated exchange in the state. Either states or the federal government may perform some exchange functions such as reinsurance and determining eligibility for federal health care programs.

State Partnership Exchange—A state may enter into a “partnership” with a federally facilitated exchange, combining state-designed and -operated functions with federally designed and operated functions. Partnership exchanges are considered a subset of federally facilitated exchanges, indicating that HHS has authority over partnerships in a federally facilitated exchange. Under this arrangement, states administer and operate plan management and/or consumer assistance activities.

SHOP—Small Business Health Options Program that assists small businesses in enrolling employees in qualified health plans offered in the small-employer market. A SHOP may be part of a larger exchange or a stand-alone exchange run by the state or federal government. The SHOP exchange is responsible for collecting and verifying information from employers and employees, determining eligibility, and facilitating enrollment.

Individual Exchange—Part of a larger exchange or a stand-alone exchange where individuals may shop for qualified health plans, apply for premium subsidies, and enroll in individual health plans. Individuals will also receive assistance in determining whether they qualify for Medicaid or other government programs. May be part of a larger federal or state exchange, or a stand-alone exchange.

State-based SHOP/federally facilitated Individual Exchange—Hybrid system where a state establishes and administers a SHOP exchange and the federal government sets up and runs the individual exchange for the state.

As of September 2013, 16 states and the District of Columbia had secured HHS approval to create their own exchanges, 7 to enter into partnership exchanges, 26 to have federally facilitated exchanges, and 1 to have a state-based SHOP/federally facilitated individual exchange. The exchanges will begin offering insurance to qualified individuals and businesses on October 1, 2013. The insurance policies, and the exchanges, are to be fully effective on January 1, 2014.²

An exchange is not an insurer, but is rather a type of marketplace where private insurance companies may sell qualified health plans (QHP) that meet certain federal standards.³ Consumers,

¹ CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

² Ibid. To qualify to use an exchange, an individual must be a citizen, national, or noncitizen who is lawfully present in the United States; must not be incarcerated, other than pending the disposition of charges; and must meet applicable state residency standards.

³ Qualified health plans must meet ACA guidelines regarding benefits, cost-sharing and other features. Exchanges will use a single application to determine eligibility for enrollment in QHPs, for federal assistance and government (continued...)

businesses, and issuers are not required to use the exchanges to purchase insurance. However, individuals must buy exchange-based coverage to qualify for federal premium tax credits and cost-sharing subsidies.⁴ Small businesses that apply for coverage through the exchanges may be eligible for small business tax credits.⁵ Consumers may apply for coverage over the phone, online, via mail, or in person in some areas.

The Congressional Budget Office (CBO) projects that 29 million individuals will be enrolled in health insurance through the exchanges in 2023.⁶ These enrollees are expected to be poorer, more racially and ethnically diverse, less educated, and less familiar with insurance than those who currently have health insurance coverage.⁷ To help these consumers negotiate the enrollment process, the ACA requires exchanges to perform education and outreach functions. Exchanges may use a variety of techniques to reach out to the public including mailings, brochures, social media, corporate partnerships, health fairs, and other public events.

Consumer Assistance Programs

Under the ACA and implementing regulations issued by the HHS Centers for Medicare & Medicaid Services (CMS), consumer assistance⁸ outreach programs include the following:

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programs such as Medicaid, and the Childrens’ Health Insurance Program (CHIP).

⁴ CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Thomas Gabe.

⁵ CRS Report R41158, *Summary of Small Business Health Insurance Tax Credit Under the Patient Protection and Affordable Care Act (ACA)*, by Manon Scales and Annie L. Mach.

⁶ Congressional Budget Office, “CBO’s Estimate of the Net Budgetary Impact of the Affordable Care Act’s Health Insurance Coverage Provisions Has Not Changed Much Over Time,” Table 1, May 14, 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf.

⁷ Testimony of Gary Cohen, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, House Committee on Oversight and Government Reform, May 21, 2013, <http://oversight.house.gov/wp-content/uploads/2013/05/Cohen-Testimony-Final.pdf>, and U.S. Census Bureau, <http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2011/Table7.pdf>.

⁸ Navigator program regulations can be found at 45 CFR Part 155.210; <http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=8614bcc3938647b1f40def8fc1076542&ty=HTML&h=L&r=PART&n=45y1.0.1.2.70#45:1.0.1.2.70.3.27.3>. Published *Federal Register* proposals and rules include: Department of Health and Human Services, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Proposed Rule,” 45 CFR Parts 144 and 145, July 15, 2011, <http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf>; Department of Health and Human Services, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule,” 45 CFR Parts 155, 156, and 157, March 27, 2012, <http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf>; Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Proposed Rule,” 45 CFR Part 155, April 5, 2013, <https://federalregister.gov/a/2013-07951.pdf>; Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards; Proposed Rule,” 45 CFR Parts 144, 147, 153, et al., June 19, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-06-19/pdf/2013-14540.pdf>; Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Centers for Medicare & Medicaid Services, “Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, Final Rule,” 42 CFR Parts 430, 431, 433, et al., 45 CFR Part 155, p. 42159 -42322, July 15, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf>; Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator

(continued...)

- Mandatory navigator programs⁹ designed to provide “fair and impartial” information about exchange-based insurance plans, as well as the availability of federal assistance to help defray the cost of insurance and other health programs.
- Non-navigator or “in-person assistance” programs at state-run exchanges and state partnership exchanges.¹⁰ The non-navigators will perform generally the same functions as navigators,¹¹ or complement the role of navigators by reaching out to underserved populations,¹² but will have a separate source of federal funding via exchange establishment grants. Non-navigators are optional at state exchanges, and mandatory at certain partnership exchanges.
- Certified application counselors to help individuals apply for QHP enrollment and possible subsidies.¹³ Exchanges may designate various organizations or individuals as application counselors or allow outside organizations to certify the counselors. Counselors are mandatory, but their duties will be more limited than those of navigators and non-navigators. No new ACA funds are provided for the counselors, though they may be funded through existing state, local, or federal programs.

In addition, consumers and businesses may use insurance brokers and agents, including web-based brokers (where allowed by states), to purchase QHPs.¹⁴ Brokers and agents, licensed by states, are generally paid a commission by insurance companies for selling their policies. Brokers and agents may apply to serve as navigators, but may not accept direct or indirect compensation from health or stop-loss insurers in this role.

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Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, July 17, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>; and Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule,” 45 CFR Parts 147, 153, 155. et al., August 30, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21338.pdf>.

⁹ ACA, Section 1311.

¹⁰ 45 CFR 155.205(d) and (e) provide that each Exchange must conduct consumer assistance, outreach, and education activities, including the navigator program. According to CMS, establishing a non-Navigator consumer assistance program pursuant to 155.205(d) and (e) will help ensure that an exchange is reaching as broad a range of consumers as possible. See also Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, July 17, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>.

¹¹ Centers for Medicare & Medicaid Services, “Helping Consumers Apply & Enroll Through the Marketplace,” July 2013, <http://www.cms.gov/CCIIO/Resources/Files/Downloads/marketplace-ways-to-help.pdf>.

¹² For example, Connecticut plans to use its in-person assister position to supplement the navigators at its exchange, and “allow more coverage and flexibility both in terms of community outreach and in availability of resources during the initial enrollment period.” “State of Connecticut’s Health Insurance Exchange Level One Grant Application In-Person Assister Program,” December 21, 2012, http://www.ct.gov/oha/lib/oha/documents/hix/ct_level_1_grant_proposal_-_in-person_assisters_-_final.pdf.

¹³ 45 CFR 155.225.

¹⁴ 45 CFR 155.220. See also HHS, Center for Consumer Information and Insurance Oversight, “Role of Agents, Brokers, and Web-Brokers in Health Insurance Marketplaces,” May 1, 2013, <http://www.healthreformgps.org/wp-content/uploads/agent-broker-5-2.pdf>.

Under CMS rules, consumers could also go directly to insurance companies to obtain information about QHPs and other insurance options, and to sign up for such plans.¹⁵

Some lawmakers, as well as brokers and agents, have questioned whether CMS regulations impose sufficient training and consumer safeguards for the navigator, non-navigator, and consumer assistance programs. A number of states have passed legislation to require navigators to have additional training and licensing, or to undergo background checks.¹⁶ The ACA gives states flexibility to certify or license navigators, but state actions may not prevent the implementation of Title I of the ACA, which authorizes the exchanges. CMS has interpreted the law to mean that states may not require all navigators, for example, to be licensed as insurance agents or brokers or to carry certain liability insurance.¹⁷ This report outlines federal and state oversight of navigators, the role of brokers and agents, and previous education and outreach efforts for federal health care programs.

Navigator Program

The navigator program is described in Section 1311(i) of the ACA. Exchanges are required to have navigators who will perform duties that include

- conducting public education activities to raise awareness of the availability of QHPs;
- distributing fair and impartial information concerning enrollment in QHPs, and the availability of premium tax credits and cost-sharing assistance;
- facilitating enrollment in QHPs;
- referring any enrollee with a grievance, complaint, or question regarding a health plan to an applicable office of health insurance consumer assistance, a health insurance ombudsman, or any other appropriate state agency or agencies; and
- providing information that is culturally and linguistically appropriate to the population being served by the exchange.

The ACA directed the Secretary of HHS (Secretary) to establish standards for the navigator program, in collaboration with states. The Secretary is to ensure that navigators are qualified and licensed, if appropriate, and to set standards to avoid conflicts of interest in the program.

CMS regulations to implement the ACA specify that navigators may offer consumers assistance in comparing and analyzing insurance options, but may not tell applicants which health plan to select. In addition, exchanges, rather than navigators, will formally determine whether an

¹⁵ Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule,” 45 CFR Parts 147, 153, 155. et al., August 30, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21338.pdf>.

¹⁶ Katie Keith, “A Look At What State Legislatures Are Up To On Navigators,” Georgetown University Center on Health Insurance Reforms, May 19, 2013, <http://ccf.georgetown.edu/all/a-look-at-what-state-legislatures-are-up-to-on-navigators/>.

¹⁷ Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, p. 42831, July 17, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>.

applicant is eligible for tax credits and other assistance to defray the cost of health coverage. Exchanges will also formally enroll applicants into QHPs, with some exceptions.¹⁸

Eligibility to Become a Navigator

The ACA includes a list of organizations and individuals eligible to become navigators, including trade, industry, and professional associations; commercial fishing industry organizations; ranching and farming organizations; community and consumer-focused non-profit groups; chambers of commerce; unions; small business development centers; and licensed insurance agents and brokers.¹⁹ The list is illustrative rather than definitive, and other organizations may apply for navigator status. At least one navigator for each exchange must be from a community, non-profit organization.²⁰

Under the ACA, a navigator may not be a health insurer or receive direct or indirect consideration from a health insurer in connection with enrolling individuals or employees in QHPs or non-QHPs.²¹ CMS regulations further bar individuals or organizations from serving as navigators if they are issuers of stop loss insurance and their subsidiaries; associations that include members of or that lobby for the insurance industry; or entities that receive direct or indirect consideration from a health insurance or stop loss insurance issuer in connection with enrolling individuals or workers in a QHP or non-QHP.²² Stop loss insurance is a type of insurance that takes effect after a company or issuer has paid out a certain level of health care claims. Entities that self-insure (finance their own health insurance plans) often use stop-loss coverage to limit their expenses.²³

Insurance brokers and agents may apply to become navigators, but under CMS rules they may not accept compensation from health or stop loss insurers in this role. (See “Brokers and Agents.”)

¹⁸ Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel,” 45 CFR Part 155, *Federal Register*, p. 20583, April 5, 2013, <https://federalregister.gov/a/2013-07951>. The exchanges will verify information regarding citizenship or immigration status, residency, income, and other factors affecting enrollee eligibility. In certain cases agents and insurance firms may enroll individuals “as through an exchange.”

¹⁹ ACA, Section 1311, <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

²⁰ 45 CFR 155.210(c)(2). See Department of Health and Human Services, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule,” 45 CFR Parts 155, 156, and 157, March 27, 2012, p. 18332, <http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf>.

²¹ 45 CFR 155.215. See Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, p. 42831-33, July 17, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>. Consideration is defined to include any monetary or nonmonetary commission, kick-back, salary, hourly wage or payment made directly or indirectly to the entity or individual from an insurance company. Examples could include free travel, gifts or other items for steering consumers to a particular health plan.

²² Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, July 17, 2013, p. 42831-33, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>.

²³ *Ibid.* The rules bar an issuer of stop-loss insurance, a subsidiary of a stop-loss company, or an individual or entity that receives direct or indirect consideration from a stop-loss insurer for enrolling people in health insurance plans. CMS says that a navigator should not have a personal interest in whether a small employer chooses to self-insure its employees, or chooses to enroll in fully funded insurance coverage inside or outside an exchange.

In instances when a state operates a SHOP exchange, but that state’s individual exchange is run by the federal government, CMS will allow two separate navigator programs. Such states will have a federal navigator program for the individual exchange, and a state navigator program for the SHOP. SHOP navigators could fulfill their obligation to facilitate enrollment, and refer consumers with complaints or questions to applicable government offices, by referring small businesses to agents and brokers for this type of assistance, so long as applicable state law permits agents and brokers to carry out these functions.²⁴

Navigator Application Process

CMS in April 2013 released a cooperative agreement funding application²⁵ for individuals and organizations seeking to become navigators at federally facilitated and partnership exchanges. HHS received more than 830 letters of intent from organizations by its May 1, 2013, deadline. Grants to navigators were awarded on August 15, 2013.²⁶ (See “Navigator and Non-navigator Funding.”)

Section 1311(i) of the ACA includes a list of community, professional, and business-related entities eligible to apply for navigator funding. CMS regulations allow other types of entities to apply, but specify that at least one navigator for each exchange must be a non-profit community organization.

Organizations and individuals that applied for the navigator program were required to submit certain information to CMS, including²⁷

- a plan for carrying out outreach and education activities specified in the ACA and in CMS regulations;
- a description of existing relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible to enroll in a qualified health plan; or a description of how such relationships could be readily established;
- a statement attesting that the applicant is not ineligible for the program due to a financial or other relationship with health insurers;
- a plan to perform the statutory and regulatory duties of a navigator for the entire length of the agreement;
- a plan to remain free of conflicts of interest while acting as a navigator;

²⁴ 45 CFR 155.705(d) and Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule,” 45 CFR Parts 147, 153, 155. et al., August 30, 2013, p. 54117, <http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21338.pdf>.

²⁵ Centers for Medicare & Medicaid Services, Navigator Funding Application, “PPHF–2013–Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges,” April 9, 2013, <http://apply07.grants.gov/apply/opportunities/instructions/oppCA-NAV-13-001-cfda93.750-cidCA-NAV-13-001-017645-instructions.pdf>.

²⁶ Centers for Medicare & Medicaid Services, “New resources available to help consumers navigate the Health Insurance Marketplace,” August 15, 2013, <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-08-15.html>.

²⁷ Ibid.

- a plan to ensure that staff and volunteers complete all required training; and
- a plan to comply with data privacy and security standards.

Navigator applications were evaluated on criteria that included the scope of their planned activities; their planned budget; their background and experience; and their expertise in health issues, outreach, and working with underserved and vulnerable populations. Navigators must provide quarterly and final reports on their work, and comply with CMS evaluations.

Non-navigator Programs

CMS allows, but does not require, state-based exchanges to establish non-navigator programs that perform the same basic functions as navigators.²⁸ States that have entered into consumer partnership exchanges²⁹ are required as a condition of the partnership to create non-navigator programs, in addition to their navigator programs. State-based exchanges, and states in consumer partnership exchanges, may use ACA Section 1311 exchange establishment grants for non-navigator programs during their first year of operation.³⁰ The ACA prohibits exchanges from using Section 1311 exchange establishment grants for regular navigator programs, with some limited exceptions. (See the “Funding” section.)

Table I. Types of Consumer Assistance Available at Exchanges

	Location	Funding
Navigators	All exchanges.	Funded through state and federal grant programs.
In-Person Assistors/Non-Navigators	Optional for state-based exchange, Mandatory for consumer partnership exchange.	Funded through separate ACA grants or by states.
Certified Application Counselors	All exchanges.	May be funded through existing state, federal and other programs.
Agents and Brokers	All exchanges, if allowed by states.	Compensated by insurers.

Source: Centers for Medicare & Medicaid Services.

Notes: Agents and brokers may serve as navigators if they agree not to take any compensation from health insurers for insurance sales and also meet other standards.

²⁸ For a discussion of non-navigator programs see Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Proposed Rule,” 45 CFR Part 155, *Federal Register*, April 5, 2013, p. 20583, <https://federalregister.gov/a/2013-07951.pdf>; and Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, July 17, 2013, p. 42825, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>.

²⁹ Ibid. In a consumer partnership exchange, a state is responsible for the day-to-day management of the exchange navigators and the development and management of a separate in-person assistance program, and can choose to be responsible for outreach and educational activities. HHS will operate the exchange call center and website and be responsible for the funding and award of navigator grants. Centers for Medicare & Medicaid Services, “Guidance on State Partnership Exchange,” January 3, 2013, <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/partnership-guidance-01-03-2013.pdf>. A partnership exchange is a second type of partnership. In this type of exchange, states assume primary plan management responsibility.

³⁰ Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, p. 42825, July 17, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>.

CMS created the non-navigator program to address the possibility that some exchanges might not have sufficient money for education and outreach during their early months of operation. State-based exchanges can use non-navigators to fill in any gaps in their navigator programs, and provide a full range of services during their first year.³¹

Like navigators, non-navigators may not be issuers of health insurance and their subsidiaries, including stop-loss insurance; associations that include members of or that lobby for the insurance industry; or entities that receive direct or indirect consideration from a health insurance or stop-loss insurance issuer in connection with enrolling individuals or workers in a QHP or non-QHP. Non-navigator programs at consumer partnership exchanges, and state-based exchanges funded through ACA exchange grants, would be subject to the same training and conflict-of-interest restrictions as navigators.³² State-based exchanges that create non-navigator programs with their own money, rather than with exchange establishment funds, are encouraged, but not required, to use CMS navigator standards.

State-run exchanges have some flexibility in defining the roles of in-person assistance or non-navigator personnel and determining how their duties mesh with those of the navigators. Some states could require non-navigators to target different demographic groups or perform different functions than navigators.³³

Certified Application Counselors

CMS regulations require state exchanges to have certified application counselor programs to help facilitate enrollment in QHPs.³⁴ There is no new federal funding for the counselors, though state-based exchanges may use Section 1311 establishment funds for counselor training.³⁵ Exchanges are not prohibited from using existing private, state, or federal programs to fund the counselors. In addition, CMS has announced \$150 million in grants to community health centers, which could serve as application counselors, to help enroll consumers in QHPs.³⁶

Federally facilitated exchanges may designate organizations to certify their staff or volunteers to perform as certified application counselors. The exchanges are to focus on organizations that

³¹ A state-run exchange may set up or continue to operate a non-navigator program from its own funds after its first year of operation to supplement its fully funded navigator program.

³² 45 CFR 155.215. See also Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, July 17, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>. Non-navigator programs are also called in-person assistance programs.

³³ Kaiser Family Foundation, “Navigator and In-Person Assistance Programs: A Snapshot of State Programs,” April 2013, <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8437.pdf>.

³⁴ 45 CFR 155.225, Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register* p. 42824 and 42828, , July 17, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>. Helping to facilitate enrollment means helping consumers with application forms, clarifying differences among QHPs, and helping a qualified individual decide on a plan.

³⁵ Ibid.

³⁶ Department of Health and Human Services, “Health Centers to Help Uninsured Individuals Gain Affordable Health Insurance Coverage,” May 9, 2013, <http://www.hhs.gov/news/press/2013pres/05/20130509a.html#UgQP88q2rz4>.

already have systems in place for protecting personally sensitive data, such as state Medicaid and CHIP agencies, hospitals and other health care providers, or social service agencies.³⁷ State-based marketplaces may designate outside organizations to certify staff and volunteers as application counselors, or may directly certify application counselors.³⁸

Like navigators and non-navigators, certified application counselors are to provide information regarding the full range of QHPs offered at an exchange and health insurance affordability programs. The counselors must work “in the best interest” of enrollees when helping individuals and employees apply for QHPs and other coverage.³⁹ Counselors must go through exchange-approved training and comply with data security and privacy standards and applicable state and federal laws.⁴⁰ The counselors’ role will be more limited in that they will not be required to perform outreach. They may work through an exchange or navigators and non-navigators to provide appropriate services to people with disabilities or to address complaints, grievances and other questions.⁴¹

Conflict-of-Interest Rules

Navigators and non-navigators funded through Section 1311 exchange establishment funding, must attest that they are eligible entities and submit a written plan to remain free of conflicts while serving in these roles.⁴²

CMS regulations (45 CFR 155.215) state that certain business arrangements or relationships are not necessarily a bar to serving as a navigator or a non-navigator, so long as they do not prevent an entity from providing information and services in a fair, accurate, and impartial manner. To mitigate possible conflicts of interest, CMS will require covered navigators and non-navigators to reveal certain information regarding possible conflicts of interest to exchanges and consumers.

Additional information to be disclosed⁴³ includes background about

- any lines of insurance, other than health care or stop loss coverage, that a navigator intends to sell while serving as a navigator;

³⁷ Centers for Medicare & Medicaid Services, “Guidance on Certified Application Counselor Program for the Federally-Facilitated Marketplace including State Partnership Marketplaces,” July 12, 2013, <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CAC-guidance-7-12-2013.pdf>.

³⁸ Centers for Medicare & Medicaid Services, “Helping Consumers Apply & Enroll through the Marketplace,” <http://www.cms.gov/CCIIO/Resources/Files/Downloads/marketplace-ways-to-help.pdf>.

³⁹ 45 CFR Part 155.225 (c).

⁴⁰ Ibid.

⁴¹ Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, July 17, 2013, p. 42825, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>. In addition, exchanges, rather than counselors, would refer enrollees to other state or federal programs, to help them with grievances or complaints regarding health coverage.

⁴² 45 CFR 155.215, Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, July 17, 2013, p. 42833, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>.

⁴³ Ibid.

- any existing and former employment relationship during the past five years with an issuer of health or stop-loss insurance or a subsidiary;
- any existing employment relationship between any issuer of health care or stop loss insurance and an individual’s spouse or domestic partner; and
- any existing or anticipated financial, business or contractual relationships with one or more issuers of health or stop-loss insurance or their subsidiaries.

If an entity or organization is awarded a navigator or non-navigator grant, conflict-of-interest rules apply to its entire staff.

Certified application counselors would not be subject to the same conflict-of-interest regulations as navigators or non-navigators, but would be required to disclose potential conflicts of interest either to an exchange or an exchange-designated organization.⁴⁴ Examples of information to be disclosed by certified application counselors include any relationships with QHP issuers or insurance affordability programs such as Medicaid plans or Medicaid managed care organizations or any other potential conflicts.

Training and Certification

CMS regulations include training standards⁴⁵ for federally facilitated exchanges, including partnership exchanges, and for non-navigators at state-run exchanges funded through Section 1311 grants. The CMS training standards may also be used by state exchanges for their navigator programs and for any non-navigator programs funded outside of Section 1311 grants. State exchanges may also develop their own training, which would have to be approved by HHS.⁴⁶

Navigator and Non-navigator Training

To be certified by an exchange, navigator and non-navigator personnel at federally facilitated exchanges, including partnership exchanges, and all federally funded non-navigators at state-based exchanges, must

- Complete up to 30 hours of HHS-approved training and receive a passing score on HHS-approved exams. Annual certification or recertification is required.
- Be prepared to serve both the individual and small business exchange and to provide services that meet the language and cultural needs of various populations, and of disabled individuals.

⁴⁴ 45 CFR 155.225(d)(2). Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, p. 42825-26, July 17, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>.

⁴⁵ 45 CFR 155.215(b) Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, July 17, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>.

⁴⁶ *Ibid.*, p. 42837.

While CMS originally called for up to 30 hours of training, more recent CMS announcements reference 20-30 hours of training.⁴⁷ The Medicare Learning Network online navigator training is estimated to take 20 hours to complete. State-run exchanges may have much more extensive training.⁴⁸

CMS rules require that navigators and covered non-navigators undergo training that includes eligibility and enrollment rules and processes; the full range of QHPs offered at an exchange; the range of insurance options including Medicaid and CHIP and other public programs; eligibility requirements for government assistance; the tax implications of enrollment decisions; privacy and security requirements; eligibility and enrollment rules and how to appeal an enrollment decision; outreach methods, and how to work effectively with people with disabilities or limited language skills. Privacy training must include processes for safeguarding health information, income and tax information, and Social Security numbers. The CMS August 2013 *Health Insurance Marketplace Navigator Standard Operating Procedures Manual* is a guide for navigators in helping consumers.⁴⁹

The regulations also require that navigators must develop, maintain, and regularly update a body of general knowledge about the racial, ethnic and cultural groups in their service area, including the primary language spoken. Navigators and non-navigators must provide information in a consumer’s preferred language at no cost to the consumer, as well as auxiliary aids and services for the disabled, at no cost where necessary.⁵⁰ Navigators and non-navigators are required to recruit and promote a staff that is representative of the demographic characteristics of their service area, including the languages spoken. Navigators and non-navigators must also provide appropriate materials and assistance to individuals with disabilities.

Certified Application Counselor Training

Certified application counselors will have to complete and achieve a passing score on a certification exam. Training materials will be more limited than for the navigator program,⁵¹ because the counselor program is more limited. For example, counselors will not have to receive training regarding certain federal health programs since they will not be directly referring potential enrollees to such programs. Counselors could also refer individuals with disabilities to

⁴⁷ HHS, “New Resources Available to Help Consumers Navigate the Health Insurance Marketplace,” August 15, 2013, <http://www.hhs.gov/news/press/2013pres/08/20130815a.html> and HHS letter to Representative Fred Upton, September 9, 2013.

⁴⁸ Henry J. Kaiser Family Foundation, “Navigator and In-Person Assistance Programs: A Snapshot of State Programs,” April 2013, http://www.healthexchange.ca.gov/BoardMeetings/Documents/April%202013,%202013/Reports%20and%20Research%20-%20Master_April.pdf#page=36.

⁴⁹ CMS, *Health Insurance Marketplace Navigator Standard Operating Procedures Manual*, August 2013, <http://www.healthreformgps.org/wp-content/uploads/navigator-SOP-manual-8-26.pdf>.

⁵⁰ 45 CFR 155.215 (c 1), and Centers for Medicare & Medicaid Services, Navigator Funding Application, “PPHF–2013–Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges,” April 9, 2013, <http://apply07.grants.gov/apply/opportunities/instructions/oppCA-NAV-13-001-cfda93.750-cidCA-NAV-13-001-017645-instructions.pdf>.

⁵¹ 45 CFR 155.225 (d)(1), and Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, p. 42846, July 17, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>.

navigator or non-navigator programs or to an exchange call center to ensure they receive appropriate services.

Privacy Protections

CMS regulations to implement the ACA include rules and procedures designed to protect enrollee privacy (45 CFR 155.260). (See the **Appendix**.) The privacy and information requirements, which are in addition to other applicable state and federal laws, generally limit the collection, use, retention and disclosure of personally identifiable information such as Social Security numbers. CMS regulations require exchanges to include these security and privacy requirements in any contract with non-exchange entities such as navigators, brokers, and agents that

- gain access to personally identifiable information submitted to an exchange; or
- collect, use or disclose personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing the functions outlined in the agreement with the exchange.⁵²

CMS regulations also require that navigators and non-navigators receive training in privacy standards and procedures, as part of their overall training. Personnel who willingly violate exchange privacy and security policies are subject to a fine of up to \$25,000 per disclosure. States may set additional eligibility criteria and background checks for navigators and non-navigators, so long as they do not prevent the application of Title I of the Affordable Care Act.

CMS has taken other actions in the case of certified application counselors.⁵³ Federally facilitated exchanges will only designate outside organizations that (1) have processes in place to screen their staff members and volunteers who are certified application counselors to ensure that they protect personally identifiable information, (2) engage in services that position them to help those they serve with health coverage issues, and (3) have experience providing social services to the community. The organizations must submit an application to an exchange and agree to comply with applicable rules and statutes. Exchanges can withdraw from the arrangements if outside organizations and their staff do not meet agreed terms or violate privacy standards, for example.

Brokers and agents are to comply with exchange privacy and security standards through agreements with federally facilitated exchanges. The agreements will spell out how agents and brokers may use personally identifiable information, their duties to protect such data and train staff in use of the information. They will also prohibit the use of such data for any purpose other than the specific functions in the agreement, related to exchange enrollment.⁵⁴

CMS will monitor federally facilitated exchanges, as well as non-exchange entities associated with the exchange, for compliance with privacy and security standards established by the exchange. In addition, the HHS will oversee and monitor state exchanges, while the state

⁵² Tax return information is covered by section 6103 of the IRS Code.

⁵³ Centers for Medicare & Medicaid Services, “Guidance on Certified Application Counselor Program for the Federally-Facilitated Marketplace including State Partnership Marketplaces,” July 12, 2013, <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CAC-guidance-7-12-2013.pdf>.

⁵⁴ Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule,” 45 CFR Parts 147, 153, 155. et al., August 30, 2013, p. 54080, <http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21338.pdf>.

exchanges will oversee non-exchange entities required to comply with the privacy and security standards set out by a state exchange. HHS oversight may include audits, investigations, inspections, and other activities.⁵⁵

Federally facilitated exchanges, non-exchange entities associated with federal exchanges, and state-based exchanges will be required to report any privacy or security incident or breach to HHS.⁵⁶ Non-exchange entities associated with state exchanges will be required to report incidents and breaches to a state exchange.

Special Enrollment Period

Under CMS regulations, exchanges must allow qualified individuals and enrollees to enroll in or change from one QHP to another in certain instances, such as gaining a dependent through birth or marriage or becoming a U.S. citizen.⁵⁷ In addition, an individual may change plans when:

A qualified individual's or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

State and Exchange Licensing and Certification

The ACA gives states and exchanges authority to impose additional licensing, certification, or other standards for navigators.⁵⁸ The ACA also contains a provision clarifying that state laws that do not prevent implementation of Title I of the ACA (which creates the exchanges and the navigator program) are not preempted by the ACA.⁵⁹

CMS regulations interpret the ACA to mean that licensing, certification, and other state and exchange standards apply so long as they do not prevent the application of ACA Title I.⁶⁰ Along those lines, CMS has determined that states and exchanges are prohibited from requiring navigators to be licensed agents or brokers, including carrying errors-and-omissions insurance. (Errors-and-omissions insurance protects against possible instances where clients claim they were

⁵⁵ Ibid and CFR 155.280

⁵⁶ Ibid, p. 54084. While initial rules called for a security breach to be reported within an hour, CMS did not include the time limit in final rules. CMS noted that the one-hour incident response timeline has been included in all data-sharing agreements required under the ACA. According to CMS: “Because the one hour incident response timeline has been included in all the data sharing agreements required under the Affordable Care Act, we have deleted the timing for incident reporting from regulation, proposed in § 155.280(c)(3), and expect it to be addressed through separate agreement.”

⁵⁷ 45 CFR 155.420, Special enrollment periods.

⁵⁸ 45 CFR 155.210(c)(1)(iii), directs that, to receive a navigator grant, an entity or individual must “meet any licensing, certification or other standards prescribed by the state or exchange, if applicable.”

⁵⁹ ACA, Section 1321(d). Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, July 17, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>. CMS regulations state that holding an agent or broker license is neither necessary, nor by itself sufficient, to perform the duties of a navigator, because licenses generally do not address areas in which navigators need expertise, including public coverage options that would be available to some consumers.

⁶⁰ Ibid.

given bad advice or were not given proper information by an agent or broker or other professional.)⁶¹

ACA regulations define an agent or broker as “a person or entity licensed by the State as an agent, broker, or insurance producer.”⁶² According to CMS, if states required that every navigator go through a specific licensing process to become an agent or broker, then agents and brokers would be the only types of navigators allowed to operate at the exchanges. That, in turn, would violate a provision of ACA rules⁶³ mandating that each exchange have at least two different types of navigators, including one community or consumer-focused non-profit group. The list of organizations and individuals eligible to become navigators includes chambers of commerce, unions and health workers. (See “Eligibility to Become a Navigator.”)

CMS regulations also state that an agent’s or broker’s license is not necessary or sufficient for performing the duties of a navigator because such licenses generally do not address training about public health program options, among other issues. While CMS did not include parallel provisions for non-navigator personnel and certified applications counselors, CMS regulations note that ACA provisions regarding preemption of state law also apply to these personnel.

Navigator and Non-navigator Funding

Federally facilitated exchanges and partnership exchanges will use federal Prevention and Public Health Fund (PPHF) dollars for grants to navigators. CMS on August 15, 2013, announced that it had awarded \$67 million in grant awards to 105 organizations at federally facilitated and partnership exchanges. The grantees will begin assisting with enrollment in October 2013.⁶⁴ (See **Table 2.**)

CMS allocated the funding for each state based on the number of uninsured residents in the state under the age of 65 as a share of the overall number of uninsured in states with a federally facilitated or partnership exchange. The amount of funding awarded to each individual navigator via the application process was based on the breadth of its proposed educational and outreach activities and the size of the population to be served. Each navigator applicant was eligible for one, non-renewable, one-year cooperative agreement award, though HHS may end funding early in certain cases.⁶⁵ Grantees included food banks, county commissioners, hospitals and health

⁶¹ 45 CFR 155.210(c)(1)(iii). Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, p. 42831, July 17, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>.

⁶² Department of Health and Human Services, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule,” 45 CFR Parts 155, 156, and 157, p. 18331, March 27, 2012, <http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf>.

⁶³ 45 CFR 155.210(c)(2).

⁶⁴ Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight, “Navigator Grant Awards” August 15, <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-8-15-2013.pdf>; and Navigator Funding Application, “PPHF–2013–Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges,” April 9, 2013, <http://apply07.grants.gov/apply/opportunities/instructions/oppCA-NAV-13-001-cfda93.750-cidCA-NAV-13-001-017645-instructions.pdf>. CMS also released a list of organizations and businesses working with HHS on outreach, in addition to other consumer assistance programs. See <http://marketplace.cms.gov/help-us/champions-for-coverage-list.pdf>.

⁶⁵ Ibid. p. 10. For example, a grant may end sooner than 12 months if a federally facilitated exchange or state (continued...)

systems, universities, legal aid societies, Planned Parenthood chapters, a health plan for uninsured fishermen, and American Indian health services.

Section 1311 of the ACA provides indefinite (i.e., unspecified) amounts of money for planning and establishment grants for exchanges. For each fiscal year, the Secretary is to determine the total to be made available to each state for exchange grants. However, no grant may be awarded after January 1, 2015.⁶⁶ ACA Section 1311 (i)(6) prohibits exchanges from using Section 1311 establishment funds to fund navigator grants. CMS regulations allow state-based exchanges and consumer partnership exchanges to use Section 1311 exchange grants to fund non-navigator assistance programs during their initial year of operation.⁶⁷ Section 1311 funds may also be used to cover an exchange’s cost of administering the navigator program, including training, grants management, and oversight.⁶⁸

Table 2. 2013 Federal Navigator Grants to Top 10 States with Highest Uninsured
Grants are for programs at federally facilitated and partnership exchanges. (In millions of dollars)

State	Number of Uninsured Under Age 65	Initial Navigator Funding Allocation
Texas	4,888,650	\$10.8
Florida	3,509,164	\$7.8
Georgia	1,698,883	\$3.8
Illinois	1,403,613	\$3.1
Ohio	1,354,868	\$3.0
North Carolina	1,346,601	\$3.0
Pennsylvania	1,242,351	\$2.7
Michigan	1,145,493	\$2.5
Arizona	947,880	\$2.1
Indiana	909,633	\$2.0
New Jersey	901,290	\$2.0

Source: CMS, Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges. Grants are funded for a 12-month period from the date of the award.

(...continued)

partnership exchange is replaced by a state-based exchange. In addition, the ability of a grantee to receive quarterly funding installments depends on whether it is in compliance with the terms and conditions of the grant.

⁶⁶ CRS Report R43066, *Status of Federal Funding for State Implementation of Health Insurance Exchanges*, by Annie L. Mach and Charles S. Redhead.

⁶⁷ Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule,” 45 CFR Part 155, *Federal Register*, p. 42825, July 17, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf>.

⁶⁸ Federally facilitated and partnership exchanges may use Section 1311 funds for certain functions, including some administrative costs, as outlined by CMS. See “Frequently Asked Questions on Allowable Uses of Section 1311 Funding for States in a State Partnership Marketplace or in States with a Federally-Facilitated Marketplace,” <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/spm-ffm-funding.html>

Some state-based exchanges have awarded grants for in-person assistance (non-navigator programs). Covered California, the California state-based exchange, announced \$43 million in funds for outreach efforts to be carried out by 48 organizations.⁶⁹ The California awards illustrate emerging, potential discrepancies in funding among exchanges, where some state-based exchanges could have greater resources than federally facilitated exchanges. (See “Outstanding Issues.”)

Brokers and Agents

U.S. health insurance agents and brokers, collectively called “producers,” are a contact point between insurance companies and applicants, helping individuals and businesses choose suitable policies.⁷⁰ According to the Bureau of Labor Statistics (BLS), producers selling all types of insurance, including health policies, held about 411,500 jobs in 2010 and had median annual wages of \$46,770.⁷¹ Insurance producers are a major segment of the U.S. financial services industry, offering annuity products, comprehensive financial planning services, such as retirement and estate planning, and business pension planning.⁷²

Though insurance producers work with consumers, they are paid by insurance companies. An agent may be a so-called captive agent who works for one insurance firm, or an independent agent who sells products from a variety of insurers. Independent agents may be paid via commission, while those working for an agency or insurer may receive a salary, often plus commission or bonus. An insurance broker generally represents a wider array of insurance products than an agent, and assumes a greater role in assessing the potential risk profile and insurance requirements of a client including overall insurance needs and appropriate policies. About 56% of producers worked for brokerages in 2010, according to BLS.

A web-based insurance broker may offer products from a variety of insurers on a central website. Potential clients enter basic information into the site, such as zip code and family size, and are then presented with an array of possible insurance plans. Shoppers can search for plans in different ways such as company name, average monthly cost, premiums, and other variables.

Licensing

With the exception of government-sponsored insurance programs (e.g., Medicare Advantage), agent and broker activity usually is regulated by the states,⁷³ which prohibit unfair sales practices and require producers to meet certain standards to become licensed.

⁶⁹ Covered California, “Outreach and Education Grant Program Reaching People Where They Live, Play and Pray,” March 14, 2013, <http://www.healthexchange.ca.gov/Documents/COVERED%20CA-%20Grantee%20Program%20Fact%20Sheet%205-14-13.pdf>.

⁷⁰ CRS Report R41439, *Health Insurance Agents and Brokers in the Reformed Health Insurance Market*, by Bernadette Fernandez.

⁷¹ U.S. Department of Labor, Bureau of Labor Standards, *2010 Occupational Outlook Handbook: Insurance Sales Agents*, <http://www.bls.gov/ooh/sales/insurance-sales-agents.htm#tab-1>.

⁷² The Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (P.L. 111-203), expanded the federal regulatory role over other areas of the insurance industry. For more background, see CRS Report R43067, *Insurance Regulation: Issues, Background, and Legislation in the 113th Congress*, by Baird Webel.

⁷³ For more information on Medicare oversight of producers see Centers for Medicare and Medicaid Services, “Chapter (continued...)”

The ACA includes several provisions that affect brokers and agents. In addition to the navigator/non-navigator program, the ACA’s Medical Loss Ratio (MLR) provisions require certain large group health plans to spend at least 85% of revenues on benefits to enrollees, rather than administration or profits; while small group and individual plans must meet an 80% MLR requirement. Under CMS regulations, commissions and fees paid to brokers and agents are counted as insurance company administrative costs. Producers say that some insurance companies have reduced their commissions in an effort to control administrative costs and meet the MLR requirements.⁷⁴

Exchange Requirements

Agents and brokers are expected to play a role in selling QHPs to both individuals and small businesses. CMS regulations⁷⁵ are designed to allow exchanges to “leverage the market presence of agents and brokers ... to draw consumers to the Exchange and to QHPs.” Exchanges may allow agents and brokers to help individuals enroll directly through an exchange website, or through outside issuer web sites, so long as they meet certain exchange standards and safeguards. Brokers or agents that discover that a potential client is qualified for federal health programs, such as Medicaid or CHIP, are expected to direct them to the appropriate public agency for assistance.⁷⁶

Federally Facilitated and Partnership Exchanges

CMS regulations set out processes for licensed agents, brokers, and web-based brokers to help consumers and employers enroll in QHPs in federally facilitated exchanges, as well as to continue to sell other, off-exchange insurance options. Federally facilitated and partnership exchanges will not pay commissions to brokers, nor will they place a cap on agent and broker commissions for selling QHPs. CMS rules will, however, require insurance companies to pay similar broker compensation for QHPs offered through such exchanges, as for similar health plans offered outside such exchanges.⁷⁷

(...continued)

3 – Medicare Marketing Guidelines For Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, Prescription Drug Plans, and Section 1876 Cost Plans,” June 2010, available at http://www.cms.gov/ManagedCareMarketing/Downloads/2011_MMG_060410.pdf.

⁷⁴ CRS Report R42735, *Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress*, by Suzanne M. Kirchhoff.

⁷⁵ 45 CFR 155.220. Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule,” 45 CFR Parts 155, 156, and 157, *Federal Register*, March 27, 2012, <http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf>; and HHS Center for Consumer Information and Insurance Oversight, “Role of Agents, Brokers, and Web-brokers in Health Insurance Marketplaces,” May 1, 2013, <http://www.healthreformgps.org/wp-content/uploads/agent-broker-5-2.pdf>.

⁷⁶ HHS, Center for Consumer Information and Insurance Oversight, “Role of Agents, Brokers, and Web-Brokers in Health Insurance Marketplaces,” p. 6, May 1, 2013, <http://www.healthreformgps.org/wp-content/uploads/agent-broker-5-2.pdf>.

⁷⁷ HHS, Center for Consumer Information and Insurance Oversight, “Role of Agents, Brokers, and Web-Brokers in Health Insurance Marketplaces,” p. 5, May 1, 2013, <http://www.healthreformgps.org/wp-content/uploads/agent-broker-5-2.pdf>.

In states with federally facilitated or partnership exchanges, CMS will require⁷⁸ agents and brokers to register by providing proof of identity, completing an exchange-specific training course, and agreeing to comply with federal and state laws and regulations, including those regarding privacy and security.

After producers have completed the required steps and are certified by an exchange they are to receive an exchange user ID, which they can use, along with their national producer number, to make transactions and receive compensation from insurers.

Brokers and agents at federally facilitated and partnership exchanges can assist consumers either

- through an issuer-based pathway, using an insurer’s website, or
- through an exchange pathway, with the agent or broker helping the consumer on an exchange website.

For federally facilitated SHOP exchanges, agents and brokers will use the exchange website to carry out employer and employee applications.⁷⁹

Issuer-Based Enrollment

Insurance agents may assist individuals seeking QHPs by directly using insurance/issuer websites, beginning in the fall of 2013. Insurers are to assign agents and brokers to sell their products, are to check the agent or broker’s license status, and are to ensure that the agent or broker is certified by an exchange.

An agent will start the process by logging on to an insurer’s website (this is applicable in situations where the issuer has satisfied exchange requirements and has direct enrollment ability). Once a consumer is ready to apply for a QHP, the issuer website will redirect the producer and the consumer to the exchange website to complete the eligibility application. As part of the process, agents and brokers are expected to disclose to the consumer that they are providing information about QHPs for which they have a business relationship, and to tell the potential enrollee that he or she may look at other QHP options on the exchange. After the consumer is verified as eligible to buy a QHP, the exchange will redirect the producer and client back to the insurer’s website to compare plans and make a selection.

Exchange Website

Agents and brokers may assist consumers and qualified small employers and employees directly on an exchange website. Agents and brokers may help consumers create exchange accounts, but the consumer (or an authorized representative) must create his or her own secure password and user name and should not share that information with third parties, including producers. When an agent uses an exchange website, all QHPs are to be displayed.

⁷⁸ Ibid.

⁷⁹ CMS, “Federally-facilitated Marketplace: Agent/Broker Training Launch,” August 2013, <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/agent-broker-training-webinar.pdf>

State-Based Exchanges

State-based exchanges will continue to license and regulate agents and brokers, including those who sell QHPs through the exchange. States may require continuing education or exchange-based training for producers, including state-specific training. States may implement additional requirements, such as mandating that producers provide information to consumers about all available QHPs, not just those for which they receive a commission. State-based exchanges may allow brokers and agents to be directly compensated through an exchange or through issuer-based commissions, and may allow agents and brokers to help enroll an individual in a QHP in a “manner than constitutes enrollment through the exchange.”

Web-Based Brokerages

Federally facilitated and partnership exchanges are to work with web-based brokers, to the extent allowed by a state (the main entity licensing and regulating agents and brokers). While state-based marketplaces have latitude to set conditions for web-based brokers, CMS regulations require that the exchanges must perform enrollee eligibility determinations for individuals who sign up for QHPs. In addition, the state-based exchanges must transmit enrollment information to QHP issuers for all individuals enrolling through the marketplace.

CMS regulations impose additional marketing restrictions on web-based brokers to ensure, in part, that consumers do not mistake their websites for official exchange websites.⁸⁰ Web-based brokers must display available information on QHPs offered through an exchange, and provide consumers with the ability to view all exchange QHPs. Web brokers may not provide financial incentives, such as rebates or giveaways, and must allow consumers to withdraw from the application process and use the exchange website at any time.⁸¹

CMS will require web-based brokers to display a disclaimer including the fact that their website might not contain all QHP information available on the exchange website. Web brokers selling products offered on federally facilitated exchanges will have to use a HHS-approved disclaimer indicating that the website is not a federally facilitated exchange website, that their website might not contain all QHP information available on the exchange website, and that the broker is subject to exchange marketing and privacy regulations. Brokers must also provide links to the appropriate exchange.⁸² CMS is currently developing guidance regarding display of such disclaimers.

⁸⁰ Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule,” 45 CFR Parts 147, 153, 155. et al., August 30, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21338.pdf>.

⁸¹ 45 CFR 155.220

⁸² Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule,” 45 CFR Parts 147, 153, 155. et al., August 30, 2013, p. 54078, <http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21338.pdf>, and HHS, Center for Consumer Information and Insurance Oversight, “Role of Agents, Brokers, and Web-Brokers in Health Insurance Marketplaces,” May 1, 2013, <http://www.healthreformgps.org/wp-content/uploads/agent-broker-5-2.pdf>. Consumers may go to the federal website [Healthcare.gov](http://www.healthcare.gov) for background information about the insurance exchange system.

Direct Enrollment Through Insurers

CMS anticipates some consumers may contact insurance companies directly to enroll in QHPs. In such cases, exchanges would have the option of allowing insurers to enroll the consumers into QHPs in a manner that is considered to be enrollment through an exchange. Under CMS rules, in order for issuer enrollment to be considered as enrollment through an exchange, the insurer’s website must provide applicants the option of looking at all QHPs offered by the insurer, distinguish between QHPs for which the consumer is eligible and other health plans that the insurer may offer, and make clear that the tax credits and subsidies apply only to QHPs through an exchange. The insurer must use an HHS-approved disclaimer to let consumers know of other QHPs through the exchange, as well as provide a weblink to the exchange.⁸³ In addition, the insurer must charge the enrollee the same premium that is charged for the QHP on an exchange, after accounting for any federal subsidy.

If permitted by an exchange, and to the extent permitted by state law, an insurer may allow its issuer application assisters⁸⁴ to help consumers apply for an eligibility determination through an exchange; apply for tax credits and other cost-sharing; and help select a QHP offered by the issuer. There must be an agreement between the insurer and the exchange under which the issuer application assisters (1) are trained in QHP options, insurance affordability programs, eligibility, and benefit rules and regulations; (2) comply with exchange privacy and security standards; and (3) comply with state laws regarding the sale, solicitation, and negotiation of health insurance products, including laws related to agent, broker, and producer licensing; confidentiality; and conflicts of interest.⁸⁵

Previous Insurance Education and Outreach Efforts

HHS has carried out previous, major health insurance education and enrollment efforts, including enrollment efforts under the Medicare Part D prescription drug program and the Children’s Health Insurance Program (CHIP). Medicare also funds the State Health Insurance Assistance Program (SHIP), which offers education and other assistance to Medicare beneficiaries and their families. These efforts differ in significant ways from current, ACA outreach efforts, but have similarities including broad public relations and advertising components and extensive use of trained volunteers and community groups to help consumers make decisions about health insurance. CMS officials have looked to the programs for lessons and guidance as they launch the in-person assistance programs.

In general, government and private sector analyses of the earlier HHS efforts indicate that the most effective outreach includes a variety of techniques including distributing information via mass media; cooperation between federal and state agencies, non-profit and business

⁸³ CFR 156.1230 and Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule,” 45 CFR Parts 147, 153, 155. et al., August 30, 2013, p. 54146, <http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21338.pdf>.

⁸⁴ 45 CFR 155.20 defines an issuer application assister as an employee, contractor, or agent of a QHP issuer who is not licensed as an agent, broker, or producer under state law and who assists individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the exchange or for insurance affordability programs

⁸⁵ Ibid.

organizations; and the use of community groups and individual counseling to reach low-income consumers and those with language barriers or physical disabilities.

Medicare Part D

Congress approved the voluntary, Medicare Part D prescription drug program in the Medicare Modernization Act of 2003 (MMA, P.L. 108-173). Similar to the structure of the ACA, Part D enrollees may choose from a variety of private insurance plans. An estimated 42 million Medicare beneficiaries were eligible for the initial Part D benefit. The MMA also shifted dual eligible beneficiaries—individuals who qualify for both Medicare and Medicaid—to Part D from the Medicaid program. Medicare beneficiaries were eligible to apply for a transitional, temporary drug discount card program for 2004-2005, with the full Part D benefit taking effect on January 1, 2006.

Congress provided \$1 billion to implement Medicare Part D.⁸⁶ According to a GAO audit of the program, HHS used about \$99 million of the \$1 billion for direct outreach and education activities, including \$67.3 million for materials targeted at beneficiaries and \$31.6 million for efforts to reach out to Medicare providers. For example, CMS paid the public relations firm Ketchum \$47.3 million for outreach initiatives including a bus tour that targeted key cities to promote the prescription drug program.⁸⁷ Other CMS spending included more than \$234 million to operate a 1-800 help line to answer questions about the Part D program, according to the GAO.

As part of the overall effort, HHS, the Social Security Administration (SSA), state Medicaid programs, and other entities implemented a coordinated education and outreach campaign, focusing on low-income beneficiaries.⁸⁸ The project included distributing more than 70 written publications, creating the toll-free help line, and posting information on the Medicare website. CMS worked with coalitions that included the National Alliance for Hispanic Health, the National Association of Area Agencies on Aging, the National Council on Aging, and the Pharmaceutical Research and Manufacturers Association.⁸⁹ The Regional Education about Choice in Health (REACH) program was aimed at beneficiaries with language, literacy, income and other barriers to access,⁹⁰ while the Access to Benefits Coalition (ABC) was a group of nonprofits including AARP, the Salvation Army, and the American Hospital Association, and 56 local coalitions.⁹¹

⁸⁶ HHS, *Fiscal 2006 Budget in Brief*, p. 56, <http://archive.hhs.gov/budget/06budget/FY2006BudgetinBrief.pdf>. Congress transferred \$25 million of that total to the HHS Office of the Inspector General for oversight activities.

⁸⁷ Government Accountability Office, “Internal Control Deficiencies Resulted in Millions of Dollars of Questionable Contract Payments,” GAO-08-54, November 2007, <http://www.gao.gov/new.items/d0854.pdf>. The GAO review found nearly \$90 million in questionable spending.

⁸⁸ Government Accountability Office, “Medicare: Quality of CMS Communications to Beneficiaries on the Prescription Drug Benefit Could Be Improved,” GAO-06-715T, May 4, 2006, <http://www.gpo.gov/fdsys/pkg/GAOREPORTS-GAO-06-715T/html/GAOREPORTS-GAO-06-715T.htm>.

⁸⁹ Laura Summer, Ellen O’Brien, Patricia Nemore, and Katharine Hsiao, Commonwealth Fund, “Medicare Part D: State and Local Efforts to Assist Vulnerable Beneficiaries,” May 2008, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2008/May/Medicare%20Part%20D%20%20State%20and%20Local%20Efforts%20to%20Assist%20Vulnerable%20Beneficiaries/Summer_McarePartDstatelocalefforts_1126_ib%20pdf.

⁹⁰ Government Accountability Office, “Medicare: CMS’s Beneficiary Education and Outreach Efforts for the Medicare Prescription Drug Discount Card and Transitional Assistance Program,” GAO-06-139R, November 30, 2005, <http://www.gao.gov/assets/100/93875.html/>.

⁹¹ Ibid.

Pharmaceutical and insurance companies were active in outreach efforts, including the Medicare Rx Education Network.⁹² CMS also worked through State Health Insurance and Assistance Programs (see below) and increased funding to the SHIPs to help expand outreach.⁹³

Even with the coordinated efforts, millions of eligible low-income individuals did not sign up for the drug discount card, and Medicare Part D enrollment was initially less than expected. However, by 2010, 90% of those eligible had Part D drug coverage, retiree coverage subsidized by Medicare, or private coverage at least as comprehensive as the Part D benefit.⁹⁴ More than 30 million beneficiaries were enrolled in Part D plans in 2013.

State Health Insurance and Assistance Programs (SHIP)

The State Health Insurance and Assistance Program (SHIP) provides counseling and information assistance to Medicare beneficiaries and their families regarding Medicare and other health insurance issues. The SHIP is authorized under Section 4360 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). Although the program’s authorization of appropriations expired in FY1996, Congress continues to provide funding by transferring discretionary funding to the program from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

Paid and volunteer SHIP counselors provide one-on-one services to Medicare beneficiaries, both in person and by telephone. There are SHIP offices in all 50 states, as well as the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. Of the 54 SHIP grant programs, about two-thirds are administered by State Units on Aging established under the Older Americans Act (OAA extended by the OAA Extension of 2006, P.L. 109-365).

The more than 15,000 counselors at the 1,300 local SHIP sites serve more than 5 million consumers annually.⁹⁵

State SHIP programs provide training for volunteers, whose duties include answering questions about Medicare, Medigap supplemental insurance, Medicare Part C, Medicare Part D, and low-income subsidies. CMS, as part of its grant making, requires SHIPs to demonstrate how their training and certification programs will ensure that counselors provide accurate information. CMS provides materials for use in creating state certification programs, and analyzes SHIP performance each year.⁹⁶ According to a recent survey of SHIP offices, initial counselor training

⁹² *Kaiser Health News*, “Insurers, National Organizations Launch Advertising Campaigns for Medicare Rx Drug Benefit,” July 20, 2005, <http://www.kaiserhealthnews.org/Daily-Reports/2005/July/20/dr00031514.aspx?p=1>.

⁹³ HHS Secretary Michael Leavitt, *Report to Congress: Best Practices for Enrolling Low-Income Beneficiaries into the Medicare Prescription Drug Benefit Program*, 2009, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Leavitt_RTC_Best_Practices_Enrolling_LI.pdf

⁹⁴ Shinobu Suzuki, “Status Report on Part D,” Medicare Payment Advisory Commission,” January 11, 2013, <http://www.medpac.gov/transcripts/status%20report%20on%20part%20D%20for%20jan%202013.pdf>.

⁹⁵ Centers for Medicare & Medicaid Services, “Affordable Care Act State Health Insurance Assistance Program (SHIP) and Aging and Disability Resource Center (ADRC) Options Counseling for Medicare - Medicaid Individuals in States with Approved Financial Alignment Models,” August 23, 2012, http://aoa.gov/AoARoot/Grants/Funding/docs/2012/SHIP_ADRC_Duals_FOA_FINAL8_22_2012.pdf.

⁹⁶Centers for Medicare & Medicaid Services, National SHIP Resource Center, “Evaluating Your SHIP Training and Certification Program Toolkit,” August 2012, https://www.shiptalk.org/ShipTalkInfoLib/MiscDocs/OCCT_Eval_Webinar_Toolkit.pdf.

averages 20.5 hours, and about 75% of the programs require counselors to pass a certification test.⁹⁷ CMS runs a National Medicare Training Program that assists SHIP and other volunteers.

Children’s Health Insurance Program

The State Children’s Health Insurance Program (CHIP) was established in the Balanced Budget Act of 1997 (BBA 97; P.L. 105-33).⁹⁸ The law was reauthorized in The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3). In general, CHIP allows states to cover targeted, low-income children in families with no insurance and incomes above state Medicaid limits.⁹⁹

The BBA 97 allowed states to spend up to 10% of their initial CHIP benefit spending on administrative costs, including outreach (as opposed to 10% of the CHIP annual appropriated level). The law also permitted additional flexibility for states that expanded their Medicaid programs under CHIP. In this case, states were allowed to claim federal financial participation for administrative costs under either Medicaid or CHIP. In the Consolidated Appropriations Act of 2001 (P.L. 106-554), Congress permitted states to use up to 10% of their unspent FY1998 funds specifically for outreach activities. These outreach funds were above and beyond funding available under the existing 10% cap. There was also private funding to supplement the public outreach efforts, including funding from the Robert Wood Johnson Foundation.

Enrollment efforts included hiring outreach workers, ranging from welfare recipients to professionals and community groups, and distributing advertising and informational materials. As was the case with Part D, HHS and state Medicaid agencies worked with community groups, health care providers and schools to contact potential beneficiaries.¹⁰⁰ According to the GAO, enrollment began slowly but picked up. By the end of 2000, about three years after the law was enacted, all states had implemented their programs.

Federal agencies including the SSA, the Departments of Agriculture, the Interior, Education, HHS, Housing and Urban Development, Labor and the Treasury, were involved in outreach efforts. As the program progressed, states found that one-on-one efforts with community and other groups became more important in terms of connecting with hard-to-reach groups, such as immigrants and people with limited English skills.¹⁰¹ States worked with an array of groups,

⁹⁷ Tobi Johnson and Lee Thompson, The National SHIP Resource Center, “SHIP Counselor Training and Certification Programs: Findings from a National Survey,” January 2013, https://www.shiptalk.org/ShipTalkInfoLib/MiscDocs/SHIP_Training_Cert_Survey_508.pdf. The survey was distributed to the 54 state SHIP offices. Of that total, 85% answered the survey.

⁹⁸ CRS Report R40226, *P.L. 111-3: The Children’s Health Insurance Program Reauthorization Act of 2009*, by Evelyne P. Baumrucker, Elicia J. Herz, and Jane G. Gravelle.

⁹⁹ Government Accountability Office, “Pre-Existing Condition Insurance Plan: Comparison of Implementation and Early Enrollment with the Children’s Health Insurance Program,” November 10, 2011, <http://www.gao.gov/assets/590/586867.pdf>. CHIP defined a targeted, low-income child as one who is under 19 years of age, with no health insurance, and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997.

¹⁰⁰ National Health Policy Forum, “CHIP and Medicaid Outreach and Enrollment: A Hands-On Look at Marketing and Applications,” October 19, 1999, http://www.nhpf.org/library/issue-briefs/IB748_SCHIPOutreach_10-19-99.pdf.

¹⁰¹ Susan Williams and Margo Rosenbach, Mathematica, “Evolution of State Outreach Efforts under SCHIP,” *Health Care Financing Review*, Summer 2007, pp. 95-107, <http://www.mathematica-mpr.com/publications/pdfs/evolutionstate.pdf>

including religious organizations, chambers of commerce, private businesses, community health centers, and education organizations not just for outreach, but to help families fill out enrollment forms and submit applications.¹⁰² States also simplified enrollment forms, coordinated data with their Medicaid programs, and increased their use of technology to speed up the process.

CHIPRA built on this system and authorized up to \$100 million in outreach and enrollment grants for fiscal years 2009 through 2013. The bulk of the authorized funds, 80%, were to be allocated to states and community-based organizations for outreach campaigns focusing on rural areas and underserved populations. The ACA expands the time period for the CHIPRA outreach and enrollment grants through 2015 and increases the appropriation level to \$140 million for FY2009-FY2015.

There are some significant differences between initial CHIP enrollment and the exchange outreach effort. The scope of the CHIP target population is far smaller than the potential exchange population. In addition, the CHIP statute was not prescriptive in terms of telling states how to meet screening and enrollment requirements to determine eligibility for Medicaid and/or CHIP. States had an incentive to enroll children in CHIP, because the states were eligible for enhanced federal matching funds to expand coverage to low-income uninsured women and children, without necessarily expanding their Medicaid programs.

Outstanding Issues

Some lawmakers have raised questions and concerns about the navigator programs. Issues include funding sources for the federally facilitated exchanges and potential funding inequities between exchanges, as well as the adequacy of privacy protections. Two subcommittees of the House Committee on Oversight and Investigations in May 2013 held a joint hearing on implementation of the navigator program.¹⁰³

Funding

CMS in August 2013 announced \$67 million in awards for navigators at federally facilitated exchanges and partnership exchanges, with the money coming from the PPHF. Some lawmakers initially questioned whether CMS had legal authority to transfer funds from the PPHF, which was created as part of the ACA, for the navigator program.¹⁰⁴ Lawmakers have also criticized the CMS decision to create the non-navigator program. State-run exchanges may use exchange

¹⁰² Victoria Wachino and Alice Weiss, “Maximizing Kids’ Enrollment in Medicaid and SCHIP,” National Academy for State Health Policy, February 2009, http://nashp.org/sites/default/files/Max_Enroll_Report_FINAL.pdf?q=files/Max_Enroll_Report_FINAL.pdf.

¹⁰³ House Committee on Oversight and Government Reform, Subcommittee on Energy Policy, Health Care and Entitlements Subcommittee on Economic Growth, Job Creation and Regulatory Affairs, “Examining the Concerns about the ObamaCare Outreach Campaign Program,” May 21, 2013, <http://oversight.house.gov/hearing/examining-the-concerns-about-obamacare-outreach-campaign/>.

¹⁰⁴ The ACA established the Prevention and Public Health Fund to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. For more information, see CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)*, coordinated by Charles S. Redhead and Erin D. Williams.

establishment grant funds for non-navigator outreach. The ACA does not allow Section 1311 funds to be used for the navigator program.

The complex funding system for the navigators and non-navigators has also led to a situation where there could be significant differences in the amount of outreach and education funding available at state-run vs. federally facilitated exchanges that can draw from exchange establishment funds for non-navigator programs to supplement navigator activities.¹⁰⁵

For example, California, which has a state-run exchange, has awarded \$37 million in grants¹⁰⁶ from its exchange funding for its in-person assistance program. The grants are part of a \$43 million allocation for exchange outreach.¹⁰⁷ Maryland, which also has a state-based exchange, has announced \$24 million in grant funds for organizations providing consumer outreach and enrollment efforts.¹⁰⁸

By comparison, CMS awarded \$10.8 million of the \$67 million in total navigator grant awards to organizations in Texas, and about \$7.8 million to organizations in Florida, to reach residents who may qualify for health coverage through the exchange.¹⁰⁹ Both states have federally facilitated exchanges.

Adequacy of Privacy Protections

Some Members of Congress, state legislators, health care advocacy groups, and brokers and agents have raised questions about whether CMS regulations go far enough to ensure protection of enrollees’ personal information, such as Social Security numbers.

Some Members of Congress have asked HHS for additional information about how much access navigators, non-navigators and certified application counselors will have to enrollees’ personal information.¹¹⁰ Lawmakers have asked to see specific training materials and have sought information regarding handling of documents and potential background checks of navigator

¹⁰⁵ Lena Sun, “Uninsured will see differing levels of help for Obamacare in Maryland, Virginia, D.C.,” *Washington Post*, August 9, 2013, http://articles.washingtonpost.com/2013-08-09/national/41237654_1_health-insurance-insurance-marketplaces-health-care-law.

¹⁰⁶ Of the \$43 million, \$34 million has been awarded for outreach to individuals, and \$3 million for outreach to small businesses. The remaining \$6 million will be used to supplement successful outreach and education strategies in 2014. The grants run from July 2013 to December 31, 2014. See Covered California, “Covered California to Award Community Organizations \$37 Million in Grants for Outreach and Education,” May 14, 2013, <http://www.healthexchange.ca.gov/Documents/COVERED%20CA-Grantee%20Announcement%20Press%20Release%205-14-13.pdf>.

¹⁰⁷ Covered California, “Outreach and Education Grant Program Reaching People Where They Live, Play and Pray,” March 14, 2013, <http://www.healthexchange.ca.gov/Documents/COVERED%20CA-%20Grantee%20Program%20Fact%20Sheet%205-14-13.pdf>.

¹⁰⁸ Maryland Office of Lt. Governor, “Lt. Governor Anthony Brown Announces Launch of Health Insurance Consumer Assistance Program to Ready Residents and Small Employers for Open Enrollment Through Maryland Health Connection,” April 25, 2013, http://marylandhbe.com/wp-content/uploads/2013/04/Connector-entities-release_FINAL-1.pdf.

¹⁰⁹ Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight, “Navigator Grant Awards” August 15, <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-8-15-2013.pdf>.

¹¹⁰ Letter to HHS Secretary Kathleen Sebelius, May 2013, http://waysandmeans.house.gov/uploadedfiles/brady_boustany_navigator_letter_051513.pdf.

personnel. A group of 13 attorneys general in an August 14, 2013, letter also raised concerns about the privacy regulations.¹¹¹

A number of states have approved additional requirements for consumer assistance personnel. For example, Missouri has enacted a law that would require navigators to be licensed by the state before helping consumers.¹¹² The California state-run exchange, Covered California, is requiring counselors to go through background checks and fingerprinting, and to wear name tags. The exchange also plans to send out field monitors and “secret shoppers” to check up on counselors.¹¹³

The potential for privacy violations and other consumer swindles extends well beyond exchange-sanctioned consumer assistance programs, however. The Federal Trade Commission warned consumers in 2012 about scam artists seeking to obtain personal information under the guise of verifying information regarding ACA coverage.¹¹⁴

¹¹¹ Patrick Morrissey, West Virginia Attorney General, Letter to HHS Secretary Sebelius, August 14, 2013, http://www.wvago.gov/pdf/Letter%20to%20HHS%20re%20Data%20Privacy_%28final%208%2014%2013%29.pdf

¹¹² Virginia Young, “Health Insurance ‘Navigators’ Can Seek Missouri Licenses Next Month,” *St. Louis Post-Dispatch*, July 25, 2013, http://www.stltoday.com/news/local/govt-and-politics/virginia-young/health-insurance-navigators-can-see-missouri-licenses-next-month/article_cd5ddaa1-f611-5eac-96c2-ce2eb69dead9.html; also see Georgetown University Health Policy Institute, “A Look At What State Legislatures Are Up To On Navigators,” May 19, 2013, <http://ccf.georgetown.edu/all/a-look-at-what-state-legislatures-are-up-to-on-navigators/>; Commonwealth Fund, “Will New Laws in States with Federally Run Health Insurance Marketplaces Hinder Outreach?,” July 1, 2013, <http://www.commonwealthfund.org/Blog/2013/Jul/Will-State-Laws-Hinder-Federal-Marketplaces-Outreach.aspx>.

¹¹³ Anna Gorman, “National Healthcare Reform Sparks Concern about Scams,” *Los Angeles Times*, July 20, 2013, <http://www.latimes.com/news/local/la-me-health-reform-scams-20130721,0,4026545.story>; and Covered California, “Background Check Policy,” March 21, 2013, http://www.healthexchange.ca.gov/BoardMeetings/Documents/March21_2013/BRB-Covered_California_Background_Check_Policy.pdf.

¹¹⁴ Federal Trade Commission, “FTC Alert: Scammers Out to Trick Consumers Using the Supreme Court’s Affordable Care Act Ruling,” July 31, 2012, <http://www.ftc.gov/opa/2012/07/aca.shtm>; Sid Kirchheimer, “New Health Benefits Scam,” AARP, March 13, 2013, <http://www.aarp.org/money/scams-fraud/info-07-2012/affordable-care-act-scam.html>; and Herb Weisbaum, “Beware of Obamacare Scammers,” *CNBC* and *The Fiscal Times*, August 15, 2013, <http://www.thefiscaltimes.com/Articles/2013/08/15/Beware-of-Obamacare-Scammers.aspx#page1>.

Appendix. CMS Exchange Privacy Requirements

§ 155.260 Privacy and security of personally identifiable information.

(a) *Creation, collection, use and disclosure.* (1) Where the Exchange creates or collects personally identifiable information for the purposes of determining eligibility for enrollment in a qualified health plan; determining eligibility for other insurance affordability programs, as defined in 155.20; or determining eligibility for exemptions from the individual responsibility provisions in section 5000A of the Code, the Exchange may only use or disclose such personally identifiable information to the extent such information is necessary to carry out the functions described in § 155.200 of this subpart.

(2) The Exchange may not create, collect, use, or disclose personally identifiable information while the Exchange is fulfilling its responsibilities in accordance with § 155.200 of this subpart unless the creation, collection, use, or disclosure is consistent with this section.

(3) The Exchange must establish and implement privacy and security standards that are consistent with the following principles:

(i) *Individual access.* Individuals should be provided with a simple and timely means to access and obtain their personally identifiable information in a readable form and format;

(ii) *Correction.* Individuals should be provided with a timely means to dispute the accuracy or integrity of their personally identifiable information and to have erroneous information corrected or to have a dispute documented if their requests are denied;

(iii) *Openness and transparency.* There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable information;

(iv) *Individual choice.* Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable information;

(v) *Collection, use, and disclosure limitations.* Personally identifiable information should be created, collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately;

(vi) *Data quality and integrity.* Persons and entities should take reasonable steps to ensure that personally identifiable information is complete, accurate, and up-to-date to the extent necessary for the person’s or entity’s intended purposes and has not been altered or destroyed in an unauthorized manner;

(vii) *Safeguards.* Personally identifiable information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure; and,

(viii) *Accountability.* These principles should be implemented, and adherence assured, through appropriate monitoring and other means and methods should be in place to report and mitigate non-adherence and breaches.

(4) For the purposes of implementing the principle described in paragraph (a)(3)(vii) of this section, the Exchange must establish and implement operational, technical, administrative and physical safeguards that are consistent with any applicable laws (including this section) to ensure—

(i) The confidentiality, integrity, and availability of personally identifiable information created, collected, used, and/or disclosed by the Exchange;

(ii) Personally identifiable information is only used by or disclosed to those authorized to receive or view it;

(iii) Return information, as such term is defined by section 6103(b)(2) of the Code, is kept confidential under section 6103 of the Code;

(iv) Personally identifiable information is protected against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information;

(v) Personally identifiable information is protected against any reasonably anticipated uses or disclosures of such information that are not permitted or required by law; and

(vi) Personally identifiable information is securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with retention schedules;

(5) The Exchange must monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls.

(6) The Exchange must develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.

(b) *Application to non-Exchange entities.* Except for tax return information, which is governed by section 6103 of the Code, when collection, use or disclosure is not otherwise required by law, an Exchange must require the same or more stringent privacy and security standards (as § 155.260(a)) as a condition of contract or agreement with individuals or entities, such as Navigators, agents, and brokers, that:

(1) Gain access to personally identifiable information submitted to an Exchange; or

(2) Collect, use or disclose personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing the functions outlined in the agreement with the Exchange.

(c) *Workforce compliance.* The Exchange must ensure its workforce complies with the policies and procedures developed and implemented by the Exchange to comply with this section.

(d) *Written policies and procedures.* Policies and procedures regarding the creation collection, use, and disclosure of personally identifiable information must, at minimum:

- (1) Be in writing, and available to the Secretary of HHS upon request; and
 - (2) Identify applicable law governing collection, use, and disclosure of personally identifiable information.
- (e) *Data sharing.* Data matching and sharing arrangements that facilitate the sharing of personally identifiable information between the Exchange and agencies administering Medicaid, CHIP or the BHP for the exchange of eligibility information must:
- (1) Meet any applicable requirements described in this section;
 - (2) Meet any applicable requirements described in section 1413(c)(1) and (c)(2) of the Affordable Care Act;
 - (3) Be equal to or more stringent than the requirements for Medicaid programs under section 1942 of the Act; and
 - (4) For those matching agreements that meet the definition of “matching program” under 5 U.S.C. 552a(a)(8), comply with 5 U.S.C. 552a(o).
- (f) *Compliance with the Code.* Return information, as defined in section 6103(b)(2) of the Code, must be kept confidential and disclosed, used, and maintained only in accordance with section 6103 of the Code.
- (g) *Improper use and disclosure of information.* Any person who knowingly and willfully uses or discloses information in violation of section 1411(g) of the Affordable Care Act will be subject to a civil penalty of not more than \$25,000 per person or entity, per use or disclosure, in addition to other penalties that may be prescribed by law.

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